Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS RADIOLOGY GROUP
PO BOX 29407
SAN ANTONIO TEXAS 78229

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative
Box Number 01

MFDR Tracking Number
M4-11-4102-01

MFDR Date Received
July 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Received explanation of Review dated 12/13/10 from Liberty Mutual with denial 'Pre-Authorization was requested but denied for this service [sic]. Submitted a Request for Reconsideration showing that other services for the same date of service were paid, and hospital facesheet showing where a 'Verbal Approval' was obtained.'"

Amount in Dispute: $107.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Preauthorization was requested and denied. See letter attached."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 29, 2010	72148-26	$107.18	$107.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Texas Administrative Code §137.100 sets out the treatment guidelines.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - X388 – Pre-authorization was requested but denied for this service per DWC Rule 134.600
   - X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. Did the disputed service require preauthorization per 28 Texas Administrative Code §134.600?
2. Is the disputed subject to the provisions of 28 Texas Administrative Code §137.100?
3. Did the requestor seek voluntary certification for CPT code 72148?
4. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (8) unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline."

   The requestor seeks payment for CPT code 72148-26 rendered on October 29, 2010. The CPT® Code description for 72148 is "Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material."

   The requestor sought preauthorization from the insurance carrier for CPT code 72148-26 and the preauthorization was denied by the insurance carrier per the utilization review letter dated September 30, 2010. The insurance carrier denied the disputed service with denial reason code(s) "X388 – Pre-authorization was requested but denied for this service per DWC Rule 134.600" and "X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due."

   No documentation was submitted by either party to support that the disputed service 72148 is a repeat individual diagnostic study. The reimbursement rate for CPT code 72148 is under the $350.00 established Medical Fee Guideline amount, as a result the provisions of 28 Texas Administrative Code §134.600 (p)(8) does not apply to the disputed charge.

   Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."

   The disputed service is subject to the provisions of 28 Texas Administrative Code §134.600 (p) (12). Therefore the Official Disability Guidelines will be reviewed to determine if the disputed service required preauthorization.
2. Per 28 Texas Administrative Code §137.100 "(a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp,* excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning)."

   Review of the ODG documents that an MRI is a recommended treatment for the billed diagnosis, as a result preauthorization was not required for CPT code 72148 under the provisions of 28 Texas Administrative Code §134.600 and 28 Texas Administrative Code §137.100.
3. Per 28 Texas Administrative Code §134.600 "(r) The requestor and insurance carrier may voluntarily discuss health care that does not require preauthorization or concurrent review under subsections (p) and (q) of this section respectively. (3) If there is no agreement between the insurance carrier and requestor, health care provided is subject to retrospective review of medical necessity."

   Review of the submitted documentation supports that a voluntary preauthorization was sought for CPT code 72148 and denied by the insurance carrier. The requestor rendered the service and was retrospectively denied by the insurance carrier with the denial reasons indicated above.

   The division finds that preauthorization was not required for CPT code 72148 and the requestor is therefore entitled to reimbursement for the disputed service.

4. Per 28 Texas Administrative Code §134.203 “(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   The Medicare Physician Fee Schedule (MPFS) for CPT code 72148-26 is $75.69 with the application of the division conversion factor the MAR is $111.50. The requestor seeks reimbursement in the amount of $107.18, therefore $107.18 is recommended.

   Review of the submitted documentation finds that the requestor is entitled to reimbursement for CPT code 72148-26 in the amount of $107.18.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $107.18.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $107.18 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 26, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.